Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3220AGC	A. BUILDING _____ B. WING _____	11/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL PRESTIGE	3712 SPITZE DRIVE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 27364 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/24/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness and chronic illness. Four beds are licensed for Category I and six beds are licensed as Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.	Y 103		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 103	Continued From page 1 This Regulation is not met as evidenced by: Surveyor: 27364 Based on record review on 11/24/09, the facility failed to ensure 1 of 3 caregivers complied with NAC 441A.375 regarding tuberculosis (TB) testing (Employee #1). Employee #1's file had a negative chest X-Ray dated 4/10/05 and TB signs and symptoms statement dated 8/26/09, but failed to have proof of a positive TB skin test. Severity: 2 Scope: 3	Y 103		
Y 178 SS=F	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/24/09, the facility failed to ensure the exits were free of obstacles. The sliding door exit in bedroom #3 was blocked by a table on the exterior. In 1 of 3 bathrooms, the shower walls in the bathroom adjacent to bedrooms #4 and #5 were deteriorated and had evidence of mold. Severity: 2 Scope: 3	Y 178		